POWERS (C. A.)

A brief note on some cases recently admitted to the Surgical service at the New York Cancer Hospital.

A BRIEF NOTE ON SOME CASES RECENTLY ADMITTED TO THE SURGICAL SERVICE AT THE NEW YORK CANCER HOSPITAL.*

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AS a preface to the hasty remarks which I have to make on the topic embodied in the foregoing title it may be well to sketch, in short order, some of the conditions governing the institution.

Patients with real or suspected malignant disease, with neoplasms of any form, applying at the hospital are admitted to the free wards, and are divided into three classes:

1. Operable surgical cases.
2. Operable gynæcological cases.
3. Inoperable or chronic cases.

It is with the first class that I have to do, and the cases to which I shall briefly refer are those of patients who applied directly to the hospital and were admitted during the four months ending with January 31, 1894, to the active surgical wards. Cases of benign tumors are not included, nor are patients with cancer sent by me from my office to the hospital, or those referred directly to me there by physicians or former patients.

The wisdom of admitting on equal terms supposedly malignant and benign tumors is shown by the very considerable number of instances in which a neoplasm considered benign on admission has proved, on removal, to be malignant.

Examinations for admission are made by the house surgeon, and while in general inoperable cases were referred by him to their proper wards, it so happened in some instances that cases deemed operable by him were thought otherwise by the attending surgeon. These latter are included in the following list:

Cases of cancer of the breast and axillary glands, too extensive to warrant thought of cure, but seeming to demand the relief afforded by a palliative operation, 8.

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Cancer of the breast, inoperable, 4.

Cancer of the rectum, too extensive for removal, palliative inguinal colostomy, 1.

Cancer of the tongue and lower jaw, operation palliative, 2.

Cancer of the face, inoperable, 1.

Cancer of the penis and groin, inoperable, 1.

Cancer of the rectum, not advanced, Kraske's operation, 1.

Cancer of face of limited extent, 3.

Total, 21 cases; 1 post-operative death, after excision of tongue and lower jaw.

As has been said, this list does not embrace cases of benign neoplasm nor those sent into my service direct by others or by myself. If we include the inoperable cases which applied and were admitted to the incurable wards or refused admission thereto because of lack of room, we should add 22 cases, making a total of 43.

It has been my custom of late to divide operable cases, after operation, into three classes.*

1. Those in which the disease is so limited that it is thought reasonably probable that it is entirely excised and that the patient has a fair prospect of cure.

2. Those cases in which the surgeon is doubtful, after removal, whether he has gone beyond the limits of invaded tissue.

3. Cases frankly incurable, in which a palliative operation affords a fair prospect of adding to the life and comfort of the patient.

That some such classification would seem both reasonable and desirable is evident when we come to compute, after a term of years, percentages of the radical cure of cancer. Let us take, for example, that common seat, the female breast. It is manifestly unjust to include in the same category a case in which the cancerous lump in the gland was no larger than a walnut, the axillary glands being free from invasion, and one in which the entire breast is a solid mass of cancerous tissue and the glands of the axilla markedly involved. In the first instance, wide excision of the gland and a thorough dissection of the axilla offers the patient a good chance of permanent cure.

In the second case operation must be judged purely palliative.†

As illustrative instances of this division I may be allowed to cite the following cases recently under my care at the Cancer Hospital:

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*It is needless to say that no sharp lines can be drawn in any such division. One estimates an individual case as best he can.

†These palliative operations are to be recommended whenever we feel that the patients can thereby be rendered more comfortable, due estimate being made of mortality risk.

CASE I. *First Stage.*— Mrs. Y., a lady of seventy years was referred to me, in January, by her family physician on Long Island.

Two months previously she had noticed a small lump in the right breast. Examination revealed a hard nodule of the size of a small pullet's eggg, just above and without the nipple, Nothing felt in the axilla. Operation: Excision of the entire breast, pectoralis fascia, and axillary contents. A few slightly enlarged glands found in the axilla. Primary union under one dressing.

The pathologist, Dr. E. K. Dunham, reported the breast nodule carcinoma, the axillary glands hyperplastic. Prognosis fairly good.

CASE II. *Second Stage.*— Mrs. X., a woman of fifty-eight years, was referred to me by her physician in Massachusetts, in February of this year. Fifteen months ago she first noticed a small, hard lump at the upper outer quadrant of the right breast. This she showed to her physician, who called it "enlarged milk veins." It slowly increased in size and became painful.

Examination revealed a firm mass of the size of a small mandarin orange in the outer half of the breast, freely movable on the deeper tissues. Skin and nipple normal, nothing felt in the axilla. Operation, February, 1894: Excision of breast and axillary contents. A half dozen enlarged glands were found in the axilla, all within reach of investigation being removed. Primary union; the patient went home on the eleventh day. Pathological report: "Carcinoma of breast and of the axillary glands. There is a good zone of healthy tissue on all sides of the tumor." Prognosis dubious, as one can not assume that all glandular involvement was removed.

CASE III. *Third Stage.*— Mrs. Z., a woman of sixty-five years of age, was brought to the hospital by her physician in December last. Fifteen months previously she had noticed a lump in the left breast. This had slowly but steadily increased in size, its growth being watched with interest and without alarm by the patient and her physician. When admitted the breast was a solid mass of evidently cancerous tissue, lightly adherent to the chest wall.

The skin was reddened and adherent, the nipple retracted. A mass of the size of a pigeon's egg was felt in the anterior axilla.

Operation: Removal of the breast, pectoralis fascia, the axillary glands, and a part of the pectoralis major. Even after extensive dissection it was evident that all involved tissue could not be removed. Undisturbed healing.

Pathological report: "Carcinoma of breast, glands, and a part of the pectoralis muscle." Prognosis, recurrence certain.

If, now, we refer to the table of cases to which reference has been made, we see that seventeen, or eighty-one per cent, would fall in the class of inoperable or third-stage operable cases, only nineteen per cent affording to the surgeon any prospect whatever of a radical cure. And if we add the inoperable cases admitted to the chronic wards or refused for lack of room, we should have of the forty-three cases but nine per

cent which could be placed in the first stage. It may be thought unfair to add these latter cases, as the knowledge that the Cancer Hospital provides accommodation for a number of incurables leads many such to be sent to it for shelter; but I am sure that the contention that the vast majority of operable cancer cases reach the surgeon too late to warrant expectation of cure is one that will be shared by all who have to do with active surgical work.

I have purposely refrained from speaking of the therapy of these cases or making any allusion to ultimate results. I am quite content at this time to call your attention, as has been done so many times before, to the fact that if we are to cure cancer we must attack it very early, while the disease is yet essentially local.